		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016147

Facility Name: D'ADRIAN CONVALESCENT CENTER

Address: 1373 D'ADRIAN PROFESSIONAL PARK (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

Telephone Number: (618) 466-0153 **Fax #** (618) 466-0190

IDPA ID Number: 37-0955244001

Date of Initial License for Current Owners: JUNE 1972

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	29	Skilled (SNF)	29	10,585	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,297	534	1,329	3,160	8
9	SNF/PED					9
10	ICF	18,970	2,246		21,216	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,267	2,780	1,329	24,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1,329

Medicare Intermediary ADMINISTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	82,861	12,443	5,194	100,498		100,498		100,498			1
2	Food Purchase		88,086		88,086		88,086	(515)	87,571			2
3	Housekeeping	31,989	11,630		43,619		43,619		43,619			3
4	Laundry	22,532	8,417		30,949		30,949		30,949			4
5	Heat and Other Utilities			67,623	67,623		67,623		67,623			5
6	Maintenance	20,483	10,815	36,203	67,501		67,501	(693)	66,808			6
7	Other (specify):* Utility Workers	31,161			31,161		31,161		31,161			7
8	**TOTAL General Services**	189,026	131,391	109,020	429,437		429,437	(1,208)	428,229			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	799,262	67,317	2,742	869,321	(35,425)	833,896	1,490	835,386			10
10a	Therapy	25,089	1,808	139,762	166,659	(139,762)	26,897		26,897			10a
11	Activities	33,568	1,062		34,630		34,630		34,630			11
12	Social Services			3,002	3,002		3,002		3,002			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	857,919	70,187	158,706	1,086,812	(175,187)	911,625	1,490	913,115			16
	C. General Administration											
17	Administrative	39,239		4,717	43,956	1,009	44,965	33,396	78,361			17
18	Directors Fees											18
19	Professional Services			157,652	157,652		157,652	(149,997)	7,655			19
20	Dues, Fees, Subscriptions & Promotions			8,964	8,964		8,964	(2,783)	6,181			20
21	Clerical & General Office Expenses	24,407	5,888	5,719	36,014		36,014	17,496	53,510			21
22	Employee Benefits & Payroll Taxes			173,136	173,136		173,136	9,834	182,970			22
23	Inservice Training & Education			1,389	1,389		1,389	51	1,440			23
24	Travel and Seminar			1,501	1,501	(1,393)	108	537	645			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			111,356	111,356		111,356	367	111,723			26
27	Other (specify):*			24,516	24,516		24,516	(24,516)				27
28	**TOTAL General Administration**	63,646	5,888	488,950	558,484	(384)	558,100	(115,615)	442,485			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,110,591	207,466	756,676	2,074,733	(175,571)	1,899,162	(115,333)	1,783,829			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER #0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			19,250	19,250		19,250	13,927	33,177			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,665	43,665		43,665	(27,943)	15,722			32
33	Real Estate Taxes			31,653	31,653		31,653		31,653			33
34	Rent-Facility & Grounds			178,500	178,500		178,500	(174,973)	3,527			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			273,068	273,068		273,068	(188,989)	84,079			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					175,571	175,571		175,571			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,153	65,153	175,571	240,724		240,724			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,110,591	207,466	1,094,897	2,412,954		2,412,954	(304,322)	2,108,632			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,734)	30		9
10	Interest and Other Investment Income	(3,169)	32		10
11	Discounts, Allowances, Rebates & Refunds	(104)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,010)	27		13
14	Non-Care Related Interest	(483)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(346)	20		17
18	Fines and Penalties	(14,000)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(753)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,506)	27		24
25	Fund Raising, Advertising and Promotional	(2,338)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(374)	20		28
29	Other-Attach Schedule	(2,940)	VAR.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,757)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(262,373)	Various	34
35	Other- Attach Schedule **Sch XIX-H Column 8**	808	6	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (261,565)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (304,322)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy	X		139,762	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		751	10	42
43	Prescription Drugs	X		24,824	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		6,165	10	45
46	Other-Attach Schedule IV, Med Sup	X		4,069	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 175,571		47

STATE OF ILLINOIS

D'ADRIAN CONVALESCENT CENTER

ID# 0016147

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING	$ (515)	2	1
2	DEFERRED MAINT. SCH XIX-H LINE 9 COL 3	(2,425)	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(515)	0	0	0	0	0	0	0	0	0	0	(515)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,617)	0	0	0	0	0	0	0	0	0	0	(1,617)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,132)	0	0	0	0	0	0	0	0	0	0	(2,132)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	241	0	0	0	0	0	0	0	0	0	241	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(753)	(149,334)	0	0	0	0	0	0	0	0	0	(150,087)	19
20	Fees, Subscriptions & Promotions	(3,058)	150	0	0	0	0	0	0	0	0	0	(2,908)	20
21	Clerical & General Office Expenses	(104)	0	0	0	0	0	0	0	0	0	0	(104)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(241)	0	0	0	0	0	0	0	0	0	(241)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,516)	0	0	0	0	0	0	0	0	0	0	(24,516)	27
28	**TOTAL General Administration**	(28,431)	(149,184)	0	0	0	0	0	0	0	0	0	(177,615)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,563)	(149,184)	0	0	0	0	0	0	0	0	0	(179,747)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,734)	20,160	0	0	0	0	0	0	0	0	0	12,426	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,652)	(24,291)	0	0	0	0	0	0	0	0	0	(27,943)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(178,500)	0	0	0	0	0	0	0	0	0	(178,500)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(11,386)	(182,631)	0	0	0	0	0	0	0	0	0	(194,017)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,949)	(331,815)	0	0	0	0	0	0	0	0	0	(373,764)	45

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	33.33%	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
LISA KLEIN GILDAR	5.56%	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	D'Adrian Land Trust	SPRINGFIELD	LEASOR
DANA KLEIN KAVY	5.56%	MEADOW MANOR, INC.	TAYLORVILLE			
PHILIP KLEIN	5.56%	MENARD CONVALESCENT CENTER	PETERSBURG			
JERRY W. JENNINGS	8.33%	SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			
PAULA K. JENNINGS	8.33%					
SAM KLEIN	33.33%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 156,701	NURSING HOME MANAGERS, INC	66.67%	$	$ (156,701)	1
2	V	Var.	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC		69,442	69,442	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC (DIRECT ALLOCATION)		7,367	7,367	3
4	V	24	TRAVEL	241	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(241)	4
5	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE (PER PRIOR DESK AUDIT)		241	241	5
6	V								6
7	V								7
8	V	34	RENT	178,500	D'ADRIAN LAND TRUST	100.00%		(178,500)	8
9	V	30	DEPRECIATION		D'ADRIAN LAND TRUST		20,160	20,160	9
10	V	20	TRUST FEES		D'ADRIAN LAND TRUST		150	150	10
11	V	32	INTEREST INCOME		D'ADRIAN LAND TRUST		(24,291)	(24,291)	11
12	V								12
13	V								13
14	Total			$ 335,442			$ 73,069	$ * (262,373)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	JERRY W. JENNINGS	SECRETARY	MANAGEMENT	8.33					$ 12,311	17 - 7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	33.33					1,543	17 - 7	2
3	SAM KLEIN	PRESIDENT	MANAGEMENT	33.33					1,543	17 - 7	3
4											4
5		JERRY JENNINGS, SAM KLEIN, AND H. RAYMOND KLEIN WERE PAID BY									5
6		NURSING HOME MANAGERS, INC., A RELATED ORGANIZATION. TOTAL									6
7		COMPENSATION OF $9,048 FOR EACH SAM KLEIN AND H. RAYMOND KLEIN									7
8		WAS ALLOCATED AMONG THE SIX RELATED NURSING HOMES, BASED									8
9		UPON 10 HOURS PER WEEK FOR SAM KLEIN AND 10 HOURS PER WEEK FOR									9
10		H. RAYMOND KLEIN. FOR JERRY JENNINGS $72,995 OF COMPENSATION									10
11		WAS ALLOCATED AMONG THE RELATED HOMES BASED UPON 35 HOURS									11
12		PER WEEK.									12
13								TOTAL	$ 15,397		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE ATTACHED SCHEDULES								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	OWNERS	X		MORTGAGE	$3,000.00	1/1/1992	$ 350,000	$ 228,036	12/1/2010	8.0000	$ 18,989	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,000.00		$ 350,000	$ 228,036			$ 18,989	9
	B. Non-Facility Related*											
10	D'ADRIAN LAND TRUST	X		Working Capital(See Attached Schedule)		12/16/97	120,000	581,726	DEMAND	6.0000	24,193	10
11	H. RAYMOND KLEIN	X		WORKING CAPITAL		12/24/01	50,000	50,000	DEMAND	6.0000	66	11
12	SAM KLEIN	X		WORKING CAPITAL		12/28/00	30,000		DEMAND	6.0000	417	12
13												13
14	TOTAL Non-Facility Related						$ 200,000	$ 631,726			$ 24,676	14
15	TOTALS (line 9+line14)						$ 550,000	$ 859,762			$ 43,665	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	30,450	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,051	2
3. Under or (over) accrual (line 2 minus line 1).	$	601	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,052	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,653	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	33,768	8
1997	35,462	9
1998	29,893	10
1999	30,450	11
2000	31,052	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME D'ADRIAN CONVALESCENT CENTER COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0016147

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-2-01-34-03-302-017	D'ADRIAN CONV. CENTER	$ 31,051.69	$ 31,051.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,051.69	$ 31,051.69

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,520 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1971	$ 90,753	1
2	ADJUST TO PRIOR COST REPORTS			(4,261)	2
3	TOTALS			$ 86,492	3

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1972	1972	$ 762,167	$ 5,777	30	$	$ (5,777)	$ 762,167	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AIR CONDITIONER			1979	606		8			606	9
10	ROOF			1980	14,809		15			14,809	10
11	AIR CONDITIONER			1980	2,409		8			2,409	11
12	AIR CONDITIONER			1982	2,420		15			2,420	12
13	IMPROVEMENTS			1983	15,356		15			15,356	13
14	AIR CONDITIONER			1984	1,597		15			1,597	14
15	WATER HEATER			1984	5,216		15			5,216	15
16	IMPROVEMENTS			1985	13,452	486	15		(486)	13,452	16
17	IMPROVEMENTS			1986	11,941	422	15	399	(23)	11,941	17
18	WINDOWS			1987	5,150	109	15	343	234	4,974	18
19	WINDOWS & SIGN			1988	4,235	90	15	282	192	3,807	19
20	HEAT EXCHANGER			1989	1,833	39	15	122	83	1,525	20
21	IMPROVEMENTS			1990	8,489	180	15	566	386	6,509	21
22	FIRE DAMPERS			1991	9,877	209	15	658	449	7,238	22
23	ROOF			1991	10,563	224	20	528	304	5,544	23
24	WINDOWS			1991	1,050	33	15	70	37	723	24
25	ROOF			1991	40,303	1,280	20	2,015	735	20,822	25
26	AIR CONDITIONER & WINDOWS			1992	3,833	122	15	256	134	2,432	26
27	ROOF			1992	17,724	562	20	886	324	8,860	27
28	PLUMBING & HEATING			1993	11,432	362	15	762	400	6,477	28
29	SIDEWALK & CURB (PER DESK REVIEW)			1990	1,292		20	65	65	520	29
30	NON-ALLOWABLE DUE TO OWNERSHIP CHANGE					9,260			(9,260)		30
31	WINDOWS & HEAT EXCHANGER			1995	13,372	343	15	892	549	5,798	31
32	ROOF			1995	25,820	662	20	1,291	629	8,392	32
33	DOORS, PARKING LOT, & NURSE CALL			1997	20,175	517	15	1,345	828	6,053	33
34	AIR CONDITIONER & HEATING UNITS			1998	18,783	482	15	1,252	770	4,382	34
35	GAS VALVE & DOOR FRAMES			1999	2,542	65	15	170	105	421	35
36	REMODEL ROOM #102			2000	1,769	45	15	118	73	236	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2000	$ 17,720	$ 454	15	$ 1,181	$ 727	$ 2,167	37
38	DRIVEWAY	2000	18,076	463	15	1,205	742	1,707	38
39	FIRE ALARM CONTROL PANEL	2000	2,751	71	15	183	112	229	39
40	ROOFTOP HEATING UNIT	2001	4,962	101	15	276	175	276	40
41	LANDSCAPING	2001	5,350	268	10	357	89	357	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,077,074	$ 22,626		$ 15,222	$ (7,404)	$ 929,422	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 174,314	$ 15,645	$ 15,635	$ (10)	Various	$ 87,512	71
72	Current Year Purchases	7,971	1,139	819	(320)	Various	819	72
73	Fully Depreciated Assets	200,721					200,721	73
74	Less: Assets no longer in service	(117,204)					(117,204)	74
75	TOTALS	$ 265,802	$ 16,784	$ 16,454	$ (330)		$ 171,848	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,429,368	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,410	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 31,676	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,734)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,101,270	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: D'ADRIAN LAND TRUST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	119		$ 178,500			3
4	Additions							4
5								5
6								6
7	TOTAL		119		$ 178,500 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/01
Ending 12/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 178,500
13.	12/31/2003	$ 178,500
14.	12/31/2004	$ 178,500

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 8	hrs	$	1,170	$ 38,023	$	1,170	$ 38,023	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		983	35,120		983	35,120	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		1,989	66,619		1,989	66,619	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescrpts				24,824		24,824	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxy,Lab,IV,Med Supp	39-8					10,985		10,985	13
14	TOTAL			$	4,142	$ 139,762	$ 35,809	4,142	$ 175,571	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,586	$ 16,296	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	255,942	255,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,940	28,940	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 296,468	$ 301,178	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,753	13
14	Buildings, at Historical Cost		985,266	14
15	Leasehold Improvements, at Historical Cost	92,128	92,128	15
16	Equipment, at Historical Cost	234,364	353,292	16
17	Accumulated Depreciation (book methods)	(202,405)	(1,004,428)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 124,087	$ 517,011	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 420,555	$ 818,189	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 56,160	$ 56,160	26
27	Officer's Accounts Payable	50,000	50,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	581,726		29
30	Accrued Salaries Payable	26,304	26,304	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,888	4,888	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,052	31,052	32
33	Accrued Interest Payable	24,193		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 774,323	$ 168,404	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	228,036	228,036	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 228,036	$ 228,036	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,002,359	$ 396,440	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (581,804)	$ 421,749	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 420,555	$ 818,189	48

***(See instructions.)**

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (314,186)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (314,186)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(267,618)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (267,618)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (581,804)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,056,712	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,056,712	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,083	6
7	Oxygen	1,245	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 76,328	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,169	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,169	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING $515 ADMIT FEE $225 W/A $104	844	28
28a	BAD DEBT RECOVERY	8,283	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,127	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,145,336	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	429,437	31
32	Health Care	1,086,812	32
33	General Administration	558,484	33
	B. Capital Expense		
34	Ownership	273,068	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,412,954	40
41	**Income before Income Taxes (line 30 minus line 40)****	(267,618)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (267,618)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 40,270	$ 19.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,637	5,835	94,961	16.27	3
4	Licensed Practical Nurses	16,035	16,820	200,080	11.90	4
5	Nurse Aides & Orderlies	48,227	49,001	463,951	9.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,869	2,014	25,089	12.46	8
9	Activity Director	2,084	2,137	16,156	7.56	9
10	Activity Assistants	2,815	2,875	17,412	6.06	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,208	2,280	20,570	9.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,169	9,545	62,291	6.53	15
16	Dishwashers					16
17	Maintenance Workers	2,725	2,853	20,483	7.18	17
18	Housekeepers	5,178	5,245	31,989	6.10	18
19	Laundry	3,537	3,626	22,532	6.21	19
20	Administrator	2,000	2,080	39,239	18.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,328	2,455	24,407	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	5,021	5,110	31,161	6.10	33
34	TOTAL (lines 1 - 33)	110,833	113,956	$ 1,110,591 *	$ 9.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	170	$ 5,194	1 - 3	35
36	Medical Director	120	13,200	9 - 3	36
37	Medical Records Consultant	16	632	10 - 3	37
38	Nurse Consultant	32	1,210	10 - 3	38
39	Pharmacist Consultant	48	900	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	59	3,002	12 - 3	45
46	Other(specify)				46
47	ADMINISTRATIVE CONSULTANT	176	4,717	17 - 3	47
48					48
49	TOTAL (lines 35 - 48)	621	$ 28,855		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gail Shaw	Administrator	0	$ 39,239
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 39,239

B. Administrative - Other

Description	Amount
Administrative Consultant	$ 4,717
TOTAL (agree to Schedule V, line 17, col. 3)	$ 4,717
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nursing Home Managers, Inc.	Management	$ 156,701
C S C	Corp. Representation	198
Feldman,Wasser,Draper,Benson	Legal	753
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 157,652

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,051
Unemployment Compensation Insurance	20,838
FICA Taxes	83,517
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Section 125 - Cafeteria Plan	16,305
Employee Life Insurance	2,386
HBV Vaccine	1,180
Gift Certificate	1,500
Christmas Party	359
Nursing Home Managers Allocation	9,834
TOTAL (agree to Schedule V, line 22, col.8)	$ 182,970

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV Vaccine	22	$ 1,180
Gift Certificate	22	1,500
Christmas Party	22	359
TOTAL		$ 3,039

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,700
Health Care Worker Background Check	600
(Indicate # of checks performed 50)	
See Attached Schedule	3,464
D'Adrian Land Trust - Trust Fees	150
Nursing Home Managers Allocation	125
Less: Non-allowable Fees	(346)
Less: Public Relations Expense	(2,338)
Non-allowable advertising	( )
Yellow page advertising	(374)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,181

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Administrator Reimbursement	14
Miscellaneous Travel Reimbursement	94
Nursing Home Managers Allocation	537
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 645

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	COMPRESSORS	VAR '89	$ 2,328	3 YRS	$	$	$	$	$	$	$	$	$
2	COMPRESSORS	VAR '90	3,784	3 YRS									
3	PAINT	VAR '92	1,515	3 YRS									
4	PAINT & WALLPAPER	VAR '93	4,128	3 YRS									
5	PAINT & WALLPAPER	VAR '94	1,774	3 YRS									
6	PAINT & WALLPAPER	VAR '95	3,152	3 YRS	525								
7	PAINT & WALLPAPER	VAR '96	1,814	3 YRS	605	302							
8	PAINT & WALLPAPER	VAR '97	2,301	3 YRS	767	767	383						
9	PAINT & WALL REPAIR	01/01	2,425	3 YRS				808	808	809			
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 23,221		$ 1,897	$ 1,069	$ 383	$ 808	$ 808	$ 809	$	$	$

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 13 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,433 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,153
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGES 3 & 4

LINE 27 - COLUMN 3 - GENERAL ADMINISTRATIVE - OTHER

SALES TAX	$ 3,010
BAD DEBT	7,506
FINES	14,000
	$ 24,516

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

		LINE#
RECLASS FROM:		
PHYSICAL THERAPY	$ (66,619)	10a
SPEECH THERAPY	(35,120)	10a
OCCUPATIONAL THERAPY	(38,023)	10a
OXYGEN	(6,165)	10
MEDICARE DRUGS	(24,824)	10
MEDICARE SUPPLIES	(509)	10
LABORATORY	(751)	10
I V THERAPY	(3,560)	10
RECLASS TO:		
ANCILLARY SERVICES	$ 175,571	39
RECLASS FROM:		
TRAVEL	$ (1,393)	24
RECLASS TO:		
NURSE CONS. MILEAGE REIMB.	$ 384	10
ADMINISTRATIVE TRAVEL REIMB.	1,009	17

SCHEDULE XIX - PAGE 21 - SECTION F

DUES, FEES, SUBSCRIPTIONS, AND PROM

YELLOW PAGES	$ 374
PUBLIC RELATIONS	2,338
LOCAL BUSINESS COUNCILS	196
FRANCHISE FEES	105
ADMINISTRATOR TESTING	431
ADMINISTRATOR LICENSE	20
	$ 3,464

.

1OTIONS

SCHEDULE IX - PAGE 9
LINE 10 - COLUMN 10
$24,193 IS OFFSET ON SCHEDULE VII - PAGE 6 - PART B - LINE11
LAND TRUST TRANSACTIONS AND THEREFORE IS NOT INCLUDED
ON SCHEDULE VI - PAGE 5 - LINE 14.

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

PAGE 13 - LINE 83	$	31,676
NURSING HOME MANAGERS ALLOCATION		1,501
SCHEDULE V - LINE 30 - COLUMN 8	$	33,177

SCHEDULE XVII - PAGE 19 - LINE 43

RECONCILIATION OF INCOME

PAGE 19 - LINE 43	$	(267,618)
*ACCRUED MANAGEMENT FEE 12/00		(19,659)
*ACCRUED MANAGEMENT FEE 12/01		18,377
*ACCRUED INTEREST EXPENSE		24,193
INTEREST INCOME PASSED DIRECTLY TO OWNERS		(3,169)
TAXABLE INCOME	$	(247,876)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PUI
INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS A
CONFORM TO ACCRUAL ACCOUNTING METHODS.

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COST IS ALLOCATED TO DEPARTMENT
WORKED BASED UPON TIME CARDS.

IRPOSES
AND TO

CENTRAL OFFICE COST ALLOCATION
D'ADRIAN
2001

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL	LINE #
SALARIES-ADMIN	$2,679	$2,701	$2,601	$2,590	$2,523	$2,498	$2,426	$2,529	$2,373	$2,373	$2,353	$2,422	$30,069	17
SALARIES-CLERIC	1,413	1,425	1,372	1,366	1,331	1,318	1,280	1,396	1,309	1,309	1,298	1,336	16,154	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	213	214	206	206	200	198	193	12	12	12	12	12	1,490	10
ACCOUNTING	9	9	8	8	8	8	8	7	6	6	6	7	90	19
WORK COMP INS	27	27	26	26	26	25	25	22	20	20	20	21	286	22
SUPPLIES	106	107	103	103	100	99	96	11	10	10	10	10	764	21
TELEPHONE	64	65	63	62	61	60	58	52	49	49	48	50	682	21
EMPL BENEFITS	518	522	503	501	488	483	469	543	510	509	505	520	6,073	22
PAYROLL TAXES	350	353	340	338	330	326	317	235	221	221	219	225	3,475	22
TRAVEL	84	84	81	81	79	78	76	45	42	42	42	43	778	24
IN SERVICE	4	4	4	4	4	4	4	5	5	5	5	5	51	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	17	17	17	17	16	16	16	15	14	14	14	14	185	6
OWNERS COMP	310	313	301	300	292	289	281	210	197	197	195	201	3,086	17
INS-PROP,LIAB,WC	33	33	32	32	31	31	30	31	29	29	29	30	367	26
DEPRECIATION	144	145	139	139	135	134	130	112	106	106	105	108	1,501	30
RENT	327	330	318	316	308	305	296	279	261	261	259	267	3,527	34
MAINTENANCE	53	53	51	51	50	49	48	81	76	76	75	77	739	6
FEES & PUBLICAT	5	5	5	5	4	4	4	13	12	12	12	13	94	20
ADVERTISING	0	0	0	0	0	0	0	6	6	6	6	6	31	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	6,356	6,407	6,170	6,144	5,985	5,926	5,756	5,604	5,258	5,257	5,213	5,366	$69,442	
FIXED ASSETS													69,442	
EQUIP - PRIOR	11,953	12,050	11,604	11,554	11,256	11,145	10,824	10,182	9,555	9,553	9,472	9,750	10,741	
EQUIP - CURR	0	0	0	286	279	276	268	252	237	237	235	553	219	
EQUIP - FULLY DEP	1,714	1,727	1,664	1,656	1,614	1,598	1,552	1,460	1,370	1,369	1,358	1,398	1,540	
BLDG - PRIOR	1,265	1,275	1,228	1,223	1,191	1,179	1,145	1,077	1,011	1,011	1,002	1,032	1,137	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
SALARIES-ADMIN	$2,679	$1,997	$2,512	$2,617	$2,001	$2,439	$14,245
SALARIES-CLERIC	1,413	1,054	1,325	1,381	1,055	1,287	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	213	159	199	208	159	194	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	20	26	27	20	25	$145
SUPPLIES	106	79	99	104	79	97	$564
TELEPHONE	64	48	60	63	48	59	$343
EMPL BENEFITS	518	386	486	506	387	472	$2,756
PAYROLL TAXES	350	261	328	342	261	319	$1,861
TRAVEL	84	62	79	82	63	76	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	16	17	13	16	$91
OWNERS COMP	310	231	291	303	232	283	$1,650
INS-PROP,LIAB,WC	33	24	31	32	24	30	$174
DEPRECIATION	144	107	135	140	107	131	$763
RENT	327	244	307	319	244	298	$1,739
MAINTENANCE	53	39	49	51	39	48	$280
FEES & PUBLIC	5	4	4	5	4	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,356	$4,738	$5,960	$6,208	$4,746	$5,787	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,953	8,910	11,208	11,675	8,925	10,883	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,714	1,277	1,607	1,674	1,280	1,560	9,111
BLDG - PRIOR	1,265	943	1,186	1,235	944	1,152	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
SALARIES-ADMIN	$2,701	$2,019	$2,658	$2,477	$1,978	$2,412	$14,245
SALARIES-CLERIC	1,425	1,065	1,402	1,307	1,044	1,272	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	214	160	211	197	157	191	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	21	27	25	20	25	$145
SUPPLIES	107	80	105	98	78	95	$564
TELEPHONE	65	49	64	60	48	58	$343
EMPL BENEFITS	522	391	514	479	383	466	$2,756
PAYROLL TAXES	353	264	347	324	258	315	$1,861
TRAVEL	84	63	83	77	62	75	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	17	16	13	15	$91
OWNERS COMP	313	234	308	287	229	279	$1,650
INS-PROP,LIAB,WC	33	25	32	30	24	29	$174
DEPRECIATION	145	108	142	133	106	129	$763
RENT	330	247	325	302	241	294	$1,739
MAINTENANCE	53	40	52	49	39	47	$280
FEES & PUBLIC	5	4	5	4	3	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,407	$4,790	$6,307	$5,876	$4,693	$5,721	$33,794
FIXED ASSETS							
EQUIP - PRIOR	12,050	9,009	11,860	11,051	8,825	10,759	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,727	1,291	1,700	1,584	1,265	1,542	9,111
BLDG - PRIOR	1,275	953	1,255	1,169	934	1,138	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
SALARIES-ADMIN	$2,601	$1,892	$2,683	$2,471	$1,896	$2,703	$14,245
SALARIES-CLERIC	1,372	998	1,416	1,303	1,000	1,426	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	150	213	196	151	215	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	27	25	19	27	$145
SUPPLIES	103	75	106	98	75	107	$564
TELEPHONE	63	46	65	59	46	65	$343
EMPL BENEFITS	503	366	519	478	367	523	$2,756
PAYROLL TAXES	340	247	351	323	248	353	$1,861
TRAVEL	81	59	84	77	59	84	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	16	12	17	$91
OWNERS COMP	301	219	311	286	220	313	$1,650
INS-PROP,LIAB,WC	32	23	33	30	23	33	$174
DEPRECIATION	139	101	144	132	102	145	$763
RENT	318	231	328	302	231	330	$1,739
MAINTENANCE	51	37	53	49	37	53	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,170	$4,487	$6,365	$5,861	$4,498	$6,411	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,604	8,439	11,971	11,023	8,459	12,057	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,664	1,210	1,716	1,580	1,213	1,729	9,111
BLDG - PRIOR	1,228	893	1,267	1,166	895	1,276	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
SALARIES-ADMIN	$2,590	$1,859	$2,723	$2,381	$1,842	$2,850	$14,245
SALARIES-CLERIC	1,366	981	1,436	1,256	972	1,504	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	148	216	189	146	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	28	24	19	29	$145
SUPPLIES	103	74	108	94	73	113	$564
TELEPHONE	62	45	66	57	44	69	$343
EMPL BENEFITS	501	360	527	461	356	551	$2,756
PAYROLL TAXES	338	243	356	311	241	372	$1,861
TRAVEL	81	58	85	74	58	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	15	12	18	$91
OWNERS COMP	300	215	315	276	213	330	$1,650
INS-PROP,LIAB,WC	32	23	33	29	23	35	$174
DEPRECIATION	139	100	146	128	99	153	$763
RENT	316	227	332	291	225	348	$1,739
MAINTENANCE	51	37	53	47	36	56	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,144	$4,411	$6,460	$5,649	$4,369	$6,762	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,554	8,295	12,148	10,624	8,216	12,716	63,553
EQUIP - CURR	286	205	301	263	203	315	1,574
EQUIP - FULLY DEP	1,656	1,189	1,742	1,523	1,178	1,823	9,111
BLDG - PRIOR	1,223	878	1,285	1,124	869	1,346	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
SALARIES-ADMIN	$2,523	$1,972	$2,745	$2,372	$1,790	$2,844	$14,245
SALARIES-CLERIC	1,331	1,040	1,448	1,251	944	1,500	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	200	156	218	188	142	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	20	28	24	18	29	$145
SUPPLIES	100	78	109	94	71	113	$564
TELEPHONE	61	47	66	57	43	68	$343
EMPL BENEFITS	488	381	531	459	346	550	$2,756
PAYROLL TAXES	330	258	359	310	234	372	$1,861
TRAVEL	79	62	86	74	56	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	16	13	18	15	11	18	$91
OWNERS COMP	292	228	318	275	207	329	$1,650
INS-PROP,LIAB,WC	31	24	34	29	22	35	$174
DEPRECIATION	135	106	147	127	96	152	$763
RENT	308	241	335	290	219	347	$1,739
MAINTENANCE	50	39	54	47	35	56	$280
FEES & PUBLIC	4	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,985	$4,677	$6,511	$5,628	$4,247	$6,746	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,256	8,796	12,244	10,584	7,986	12,687	63,553
EQUIP - CURR	279	218	303	262	198	314	1,574
EQUIP - FULLY DEP	1,614	1,261	1,755	1,517	1,145	1,819	9,111
BLDG - PRIOR	1,191	931	1,296	1,120	845	1,343	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
SALARIES-ADMIN	$2,498	$1,884	$2,763	$2,328	$1,952	$2,820	$14,245
SALARIES-CLERIC	1,318	994	1,458	1,228	1,030	1,488	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	198	150	219	185	155	224	1,131
ACCOUNTING	8	6	9	7	6	9	45
WORK COMP INS	25	19	28	24	20	29	145
SUPPLIES	99	75	109	92	77	112	564
TELEPHONE	60	45	66	56	47	68	343
EMPL BENEFITS	483	365	534	450	378	546	2,756
PAYROLL TAXES	326	246	361	304	255	369	1,861
TRAVEL	78	59	86	73	61	88	445
IN SERVICE	4	3	4	3	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	15	13	18	91
OWNERS COMP	289	218	320	270	226	327	1,650
INS-PROP,LIAB,WC	31	23	34	28	24	34	174
DEPRECIATION	134	101	148	125	105	151	763
RENT	305	230	337	284	238	344	1,739
MAINTENANCE	49	37	54	46	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,926	$4,470	$6,554	$5,522	$4,631	$6,690	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,145	8,407	12,326	10,385	8,709	12,582	63,553
EQUIP - CURR	276	208	305	257	216	312	1,574
EQUIP - FULLY DEP	1,598	1,205	1,767	1,489	1,248	1,804	9,111
BLDG - PRIOR	1,179	890	1,304	1,099	922	1,331	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
SALARIES-ADMIN	$2,426	$1,839	$2,794	$2,432	$1,953	$2,802	$14,245
SALARIES-CLERIC	1,280	970	1,474	1,283	1,030	1,478	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	193	146	222	193	155	222	1,131
ACCOUNTING	8	6	9	8	6	9	45
WORK COMP INS	25	19	28	25	20	28	145
SUPPLIES	96	73	111	96	77	111	564
TELEPHONE	58	44	67	59	47	67	343
EMPL BENEFITS	469	356	540	470	378	542	2,756
PAYROLL TAXES	317	240	365	318	255	366	1,861
TRAVEL	76	57	87	76	61	88	445
IN SERVICE	4	3	4	4	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	16	13	18	91
OWNERS COMP	281	213	324	282	226	324	1,650
INS-PROP,LIAB,WC	30	22	34	30	24	34	174
DEPRECIATION	130	98	150	130	105	150	763
RENT	296	224	341	297	238	342	1,739
MAINTENANCE	48	36	55	48	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,756	$4,362	$6,627	$5,769	$4,634	$6,646	$33,794
FIXED ASSETS							
EQUIP - PRIOR	10,824	8,203	12,463	10,850	8,715	12,499	63,553
EQUIP - CURR	268	203	309	269	216	310	1,574
EQUIP - FULLY DEP	1,552	1,176	1,787	1,555	1,249	1,792	9,111
BLDG - PRIOR	1,145	868	1,319	1,148	922	1,323	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SALARIES-ADMIN	$2,529	$2,198	$3,101	$2,744	$2,205	$3,010	$15,787
SALARIES-CLERIC	1,396	1,213	1,711	1,514	1,216	1,661	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	11	15	14	11	15	78
ACCOUNTING	7	6	8	7	6	8	43
WORK COMP INS	22	19	27	23	19	26	135
SUPPLIES	11	9	13	12	9	13	66
TELEPHONE	52	45	64	57	45	62	325
EMPL BENEFITS	543	472	666	589	473	646	3,389
PAYROLL TAXES	235	204	288	255	205	280	1,468
TRAVEL	45	39	55	49	39	54	282
IN SERVICE	5	5	6	6	5	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	15	13	18	16	13	17	91
OWNERS COMP	210	182	257	228	183	250	1,309
INS-PROP,LIAB,WC	31	27	38	33	27	37	192
DEPRECIATION	112	98	138	122	98	134	702
RENT	279	242	342	302	243	332	1,739
MAINTENANCE	81	70	99	88	71	96	505

FEES & PUBLIC	13	11	16	14	11	16	82
ADVERTISING	6	6	8	7	6	8	40
	0	0	0	0	0	0	0
TOTAL	$5,604	$4,870	$6,871	$6,079	$4,884	$6,669	$34,977
FIXED ASSETS							
EQUIP - PRIOR	10,182	8,849	12,484	11,045	8,875	12,118	63,553
EQUIP - CURR	252	219	309	274	220	300	1,574
EQUIP - FULLY DEP	1,460	1,269	1,790	1,583	1,272	1,737	9,111
BLDG - PRIOR	1,077	936	1,321	1,169	939	1,282	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
SALARIES-ADMIN	$2,373	$2,364	$3,167	$2,721	$2,218	$2,944	$15,787
SALARIES-CLERIC	1,309	1,304	1,747	1,501	1,224	1,624	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	16	13	11	15	78
ACCOUNTING	6	6	9	7	6	8	43
WORK COMP INS	20	20	27	23	19	25	135
SUPPLIES	10	10	13	11	9	12	66
TELEPHONE	49	49	65	56	46	61	325
EMPL BENEFITS	510	508	680	584	476	632	3,389
PAYROLL TAXES	221	220	294	253	206	274	1,468
TRAVEL	42	42	56	49	40	53	282
IN SERVICE	5	5	6	6	5	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	18	16	13	17	91
OWNERS COMP	197	196	263	226	184	244	1,309
INS-PROP,LIAB,WC	29	29	39	33	27	36	192
DEPRECIATION	106	105	141	121	99	131	702
RENT	261	260	349	300	244	324	1,739
MAINTENANCE	76	76	101	87	71	94	505
FEES & PUBLIC	12	12	16	14	11	15	82
ADVERTISING	6	6	8	7	6	7	40
	0	0	0	0	0	0	0
TOTAL	$5,258	$5,238	$7,016	$6,029	$4,913	$6,523	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,555	9,517	12,748	10,954	8,928	11,851	63,553
EQUIP - CURR	237	236	316	271	221	294	1,574
EQUIP - FULLY DEP	1,370	1,364	1,828	1,570	1,280	1,699	9,111
BLDG - PRIOR	1,011	1,007	1,349	1,159	945	1,254	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
SALARIES-ADMIN	$2,373	$2,353	$3,329	$2,631	$2,024	$3,078	$15,787
SALARIES-CLERIC	1,309	1,298	1,837	1,451	1,117	1,698	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	16	13	10	15	78
ACCOUNTING	6	6	9	7	6	8	43
WORK COMP INS	20	20	29	23	17	26	135
SUPPLIES	10	10	14	11	9	13	66
TELEPHONE	49	48	69	54	42	63	325
EMPL BENEFITS	509	505	715	565	435	661	3,389
PAYROLL TAXES	221	219	309	245	188	286	1,468
TRAVEL	42	42	59	47	36	55	282
IN SERVICE	5	5	7	5	4	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	19	15	12	18	91
OWNERS COMP	197	195	276	218	168	255	1,309
INS-PROP,LIAB,WC	29	29	41	32	25	38	192
DEPRECIATION	106	105	148	117	90	137	702
RENT	261	259	367	290	223	339	1,739
MAINTENANCE	76	75	106	84	65	98	505
FEES & PUBLIC	12	12	17	14	10	16	82
ADVERTISING	6	6	8	7	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,257	$5,214	$7,375	$5,828	$4,484	$6,819	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,553	9,474	13,400	10,590	8,147	12,390	63,553
EQUIP - CURR	237	235	332	262	202	307	1,574
EQUIP - FULLY DEP	1,369	1,358	1,921	1,518	1,168	1,776	9,111
BLDG - PRIOR	1,011	1,002	1,418	1,121	862	1,311	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
SALARIES-ADMIN	$2,353	$2,350	$3,408	$2,576	$1,944	$3,157	$15,787
SALARIES-CLERIC	1,298	1,297	1,880	1,421	1,073	1,742	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	17	13	10	16	78
ACCOUNTING	6	6	9	7	5	9	43
WORK COMP INS	20	20	29	22	17	27	135
SUPPLIES	10	10	14	11	8	13	66
TELEPHONE	48	48	70	53	40	65	325
EMPL BENEFITS	505	505	732	553	417	678	3,389
PAYROLL TAXES	219	218	317	239	181	293	1,468
TRAVEL	42	42	61	46	35	56	282
IN SERVICE	5	5	7	5	4	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	20	15	11	18	91
OWNERS COMP	195	195	283	214	161	262	1,309
INS-PROP,LIAB,WC	29	29	42	31	24	38	192
DEPRECIATION	105	105	152	115	86	140	702
RENT	259	259	375	284	214	348	1,739
MAINTENANCE	75	75	109	82	62	101	505
FEES & PUBLIC	12	12	18	13	10	16	82
ADVERTISING	6	6	9	7	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,213	$5,207	$7,550	$5,706	$4,307	$6,994	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,472	9,461	13,718	10,368	7,827	12,707	63,553
EQUIP - CURR	235	234	340	257	194	315	1,574
EQUIP - FULLY DEP	1,358	1,356	1,967	1,486	1,122	1,822	9,111
BLDG - PRIOR	1,002	1,001	1,452	1,097	828	1,345	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%
SALARIES-ADMIN	$2,422	$2,155	$3,447	$2,515	$1,937	$3,312	$15,787
SALARIES-CLERIC	1,336	1,189	1,902	1,387	1,069	1,827	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	11	17	12	10	16	78
ACCOUNTING	7	6	9	7	5	9	43
WORK COMP INS	21	18	30	22	17	28	135
SUPPLIES	10	9	14	11	8	14	66
TELEPHONE	50	44	71	52	40	68	325
EMPL BENEFITS	520	463	740	540	416	711	3,389
PAYROLL TAXES	225	200	320	234	180	308	1,468
TRAVEL	43	38	61	45	35	59	282
IN SERVICE	5	4	7	5	4	7	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	12	20	15	11	19	91
OWNERS COMP	201	179	286	209	161	275	1,309
INS-PROP,LIAB,WC	30	26	42	31	24	40	192
DEPRECIATION	108	96	153	112	86	147	702
RENT	267	237	380	277	213	365	1,739
MAINTENANCE	77	69	110	80	62	106	505
FEES & PUBLIC	13	11	18	13	10	17	82
ADVERTISING	6	5	9	6	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,366	$4,774	$7,637	$5,571	$4,291	$7,338	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,750	8,675	13,876	10,123	7,797	13,333	63,553
EQUIP - CURR	553	492	788	575	443	757	3,607
EQUIP - FULLY DEP	1,398	1,244	1,989	1,451	1,118	1,911	9,111
BLDG - PRIOR	1,032	918	1,468	1,071	825	1,411	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED

DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST	1,947	1,692	2,387	2,112	0	1,697	2,317	12,152
SEPTEM	1,768	1,761	2,359	2,027	0	1,652	2,193	11,760
OCTOBER	1,815	1,800	2,546	2,012	0	1,548	2,354	12,075
NOVEMBE	1,733	1,731	2,510	1,897	0	1,432	2,325	11,628
DECEMBE	1,777	1,581	2,529	1,845	0	1,421	2,430	11,583
TOTAL	24,358	20,011	28,400	21,342	3,078	19,155	27,702	144,046
								144,046

ALLOCATION PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
AUGUST	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SEPTEMBER	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
OCTOBER	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
NOVEMBER	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
DECEMBER	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%